

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

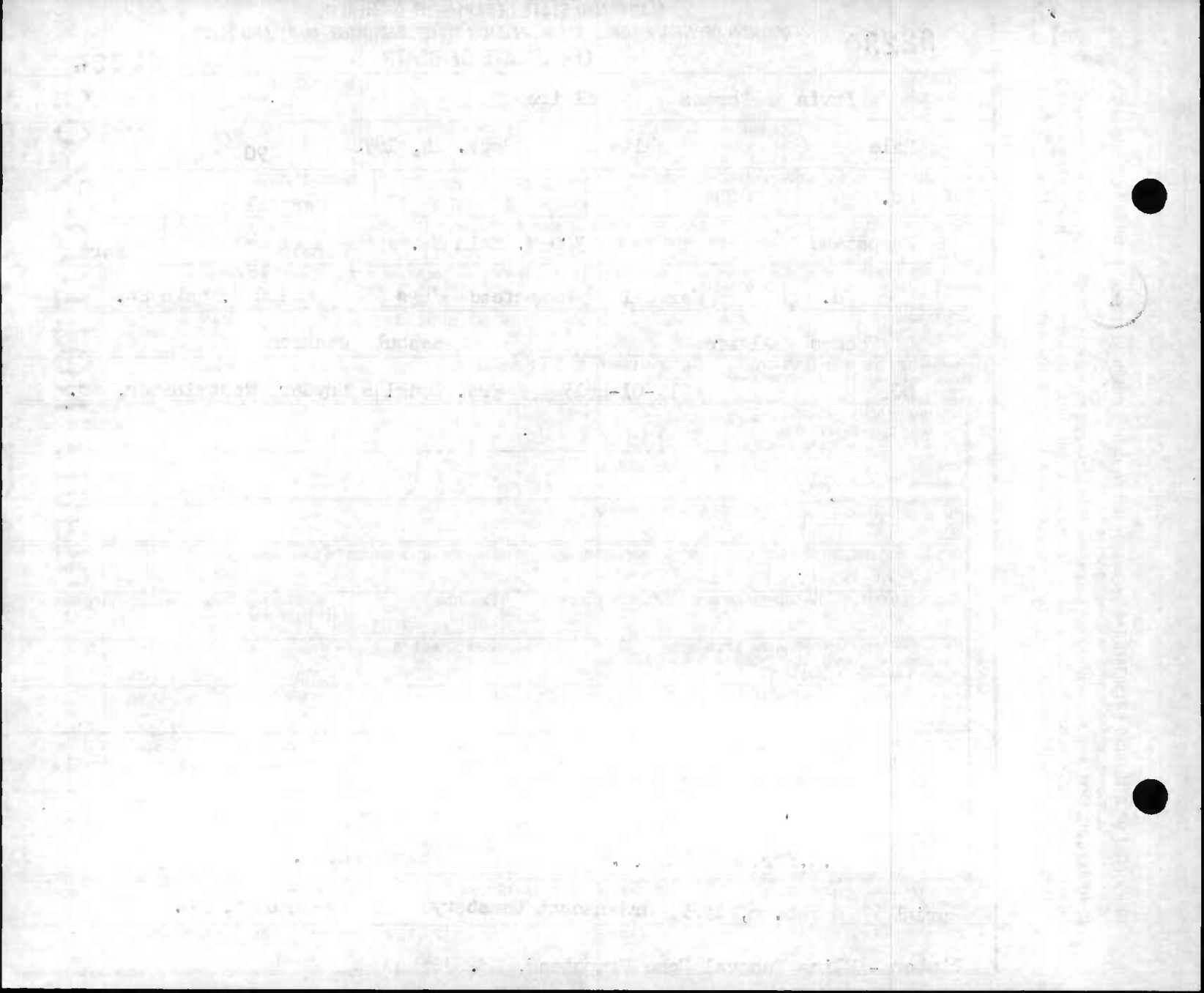
00  
06  
1

2

1

VR A15  
45M - 1

02230		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		02226	
1. DECEASED-NAME (Type or print) First Middle Last <b>Irvin Thomas Algire</b>				2a. DATE OF DEATH Month Day Year <b>Mar. 3 1969</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Sept. 14, 1878</b>	
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (In years lost birthday) <b>90</b> YRS.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b>			
10. CITY OR TOWN OF DEATH <b>Hampstead</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>300 N. Main St.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Farmer</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Hampstead</b>	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>300 N. Main St.</b>			
14. FATHER'S NAME First Middle Last <b>Thomas Algire</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Rachel Jackson</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>219-01-4519</b>		17. INFORMANT Address <b>Mrs. Douglas Snyder Westminster, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Arterio Sclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 y 0</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Cerebral Arterio Sclerosis</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan. 27</b> , 19 <b>69</b> , to <b>Feb. 3</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>Jan. 27</b> , 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>M.C. Porterfield</b>					
22c. DATE SIGNED <b>2-4-69</b>					
22d. PHYSICIAN'S NAME (Type) <b>M.C. Porterfield, M.D.</b>		22e. ADDRESS <b>Hampstead, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Feb. 6, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>	
23d. LOCATION (City or Town) (County) (State) <b>Greenmount, Md.</b>					
24. FUNERAL DIRECTOR <b>Tipton - Eline Funeral Home Hampstead, Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>8 1969</b>	
25b. REGISTRAR'S SIGNATURE <b>William J. Judge</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02231										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										02227									
Item 15 Film 410 3/4/69 kk										CERTIFICATE OF DEATH																			
1. DECEASED-NAME (Type or print)					First Middle Last					2a. DATE OF DEATH					2b. HOUR														
Lucie					GREGORY Anders					Feb Month 17 Day 1969 Year					11:30 AM														
3. SEX					4. RACE					5. DATE OF BIRTH					6. AGE (In years last birthday)					IF UNDER 1 YEAR					IF UNDER 24 HRS.				
Female					White					6/20/91					27 YRS.					MONTHS DAYS HOURS MIN.									
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH					Md.									
Virginia					U.S.A.										Carroll														
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY														
Manchester					Nursing Home					Housewife					OWN HOME														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER									
Md					Carroll					New Windsor					YES					208 MAIN ST									
14. FATHER'S NAME					First Middle Last					15. MOTHER'S MAIDEN NAME					First Middle Last														
W.M.					R. Gregory					NANNIE					Haskins - BAKER														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)					16b. SOCIAL SECURITY NO.					17. INFORMANT					Address														
no					216-60-9046					Jennie Earle Anders					208 Main St New Windsor Md														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 4369 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized arteriosclerosis</u> 5 y. DUE TO, OR AS A CONSEQUENCE OF (c)															2 MON														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from 12/17, 1968, to Feb 17, 1969, that (I) (we) last saw the deceased alive on Feb 14, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE W.H. Foard M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>															22c. DATE SIGNED 2/17/69														
22d. PHYSICIAN'S NAME (Type) W.H. Foard M.D.															22e. ADDRESS 25 N. Main St Manchester, Md 21102														
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE 12/20/69					23c. NAME OF CEMETERY OR CREMATORY METHODIST					23d. LOCATION (City or Town) (County) (State) UNIONTOWN MD														
24. FUNERAL DIRECTOR W.H. Foard Sons New Windsor, Md ADDRESS															25a. REC'D BY REGISTRAR DATE FEB 20 1969					25b. REGISTRAR'S SIGNATURE Richard Judge									

1935

1935

1935

1935

1935

1935

1935

1935

1935

1935

1935

1935

1935

1935

1935

1935

1935

1935

1935

1935

1935

1935

1935

1935

1935

1935

1935

1935

1935

1935

1935

1935

1935

1935

1935

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 5 Filing 410

3/14/69 kk

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02223

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02228

1. DECEASED-NAME (Type or Print) <b>Elijah</b> First Middle Last		2a. DATE KNOWN OF ESTI-DEATH MATED <input type="checkbox"/> <b>Feb 21</b> 19 <b>69</b> 7:35p M		2b. HOUR	
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH <b>MAY 11, 1883</b>	6. AGE (In years last birthday) <b>86</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD Month <b>Feb</b> Day <b>21</b> Year <b>1969</b> 7:35p M
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <b>Carroll</b>		10. CITY OR TOWN OF DEATH <b>Sykesville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hospital</b>	
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Farm laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b> COUNTY <b>Balto. City</b>	
13b. CITY OR TOWN <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER <b>unknown</b>	
14. FATHER'S NAME First Middle Last <b>HAMILTON ARNOLD</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>EMMA STALLINGS</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)	
16b. SOCIAL SECURITY NO. <b>220-54-6645</b>		17. INFORMANT ADDRESS <b>Springfield State Hospital Records</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral pneumonia</b> <b>4123</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Fracture, left femur</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days</b>  <b>years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Schizophrenic reaction, paranoid type.</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month Day Year <b>5:45 P.M. 2-14-1969</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Patient fell to floor hitting buttocks. Complained of pain</b>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Men's Group, Springfield State Hospital, Sykesville, Carroll, Md.</b>			
21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>M.C. Porter Field</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>2/21/69</b>	
EXAMINER'S NAME (Type) <b>M.C. PORTER FIELD</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
ADDRESS (Street, City, Town or County) <b>Springfield State Hospital, Sykesville, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3-6-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Luke Cemetery</b>	
23d. LOCATION (City or Town) <b>Sykesville, Md.</b>		23e. REC'D BY REGISTRAR <b>MAR 10 1969</b>		23f. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
24. FUNERAL DIRECTOR <b>Harry W. Haight</b> ADDRESS <b>Sykesville, Md.</b>					

82334

BARRETT, JAMES H. (1915-1980)

1915-1980

1915-1980

1915-1980

1915-1980

1915-1980

1915-1980

1915-1980

1915-1980

1915-1980

1915-1980

1915-1980

1915-1980

1915-1980

1915-1980

1915-1980

1915-1980

1915-1980

1915-1980

1915-1980

1915-1980

1915-1980

1915-1980

1915-1980



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
WALTER BLAINE BAILE						Month Day Year			7:00 AM		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)		
Male			White			JUNE 6, 1969			84 YRS.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Maryland			U.S.A.						CARROLL Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Sykesville			Springfield State Hosp.			Ret. R. R. Employee			Railroad		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Maryland			Carroll			Union Bridge			25 N. Main Street		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
JOSEPH BAILE			LAURA FLECKINGER								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
no			721-18-9611-A			Springfield State Hosp. Records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4123 Bilateral bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Heart failure DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic heart disease										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
										days	
										days	
										years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) phrase Chronic Brain Syndrome assoc. with circulatory disturbance without qualifying											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 01/20, 1969, to 02/06, 1969, that (I) (we) last saw the deceased alive on 02/06, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Francis J. Ceballos, M.D. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22c. DATE SIGNED 02/06/69											
22d. PHYSICIAN'S NAME (Type) Francisco J. Ceballos, M.D. 22e. ADDRESS Springfield State Hospital											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
BURIAL			2/4/69			PIPE CREEK			NEW WINDSOR RURAL MD		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Francis J. Ceballos, M.D.			UNION BRIDGE MD			DATE FEB 10 1969			Francis J. Ceballos, M.D.		

21230

10/10/70

10/10/70

10/10/70

10/10/70

10/10/70

10/10/70

10/10/70

10/10/70

10/10/70

10/10/70

10/10/70

10/10/70

10/10/70

10/10/70

10/10/70

10/10/70

10/10/70

10/10/70

10/10/70

10/10/70

10/10/70

10/10/70

10/10/70

10/10/70

10/10/70

10/10/70

10/10/70

10/10/70

10/10/70

10/10/70

10/10/70

10/10/70

10/10/70

10/10/70

10/10/70

10/10/70



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
45M - 1

02234										02230											
1. DECEASED-NAME (Type or print) First Middle Last										2a. DATE OF DEATH Month Day Year										2b. HOUR	
Ella Virginia Baker										2 - 14 - 69										5:59 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years lost birthday) YRS.				IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.							
Female		White		6 - 5 - 09				59 YRS.													
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH							Md.					
Virginia			Frederick						Carroll												
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY									
Sylkesville				Springfield State Hosp				Housewife													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER									
Maryland				Frederick				Frederick		YES		202 E. 4th. Street									
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last																		
Ross			ATKINS			Ada ATKINS															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO.		17. INFORMANT Address															
No						Records, Springfield State Hospital															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY:																					
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease												Years									
4123 DUE TO, OR AS A CONSEQUENCE OF																					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												Years									
(b) Generalized Arteriosclerosis advanced																					
DUE TO, OR AS A CONSEQUENCE OF																					
(c)																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
				19																	
21d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No.		City or Town		County		State							
22a. I certify that (I) (this hospital) attended the deceased from Nov. 28, 1961, to Feb. 14, 1969, that (I) (we) last saw the deceased alive on Feb. 14, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE						DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED											
Francisco J. Ceballos, M.D.										Feb. 14, 1969											
22d. PHYSICIAN'S NAME (Type) Francisco J. Ceballos, M.D.						22e. ADDRESS															
						Springfield State Hospital															
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)											
Burial				Feb. 17-1969		Mt. Olivet Cemetery				Frederick, Md. 21701											
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY-REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Elwood T. M.R. Etchison & Son						Frederick, Md. 21701		FEB 18 1969													

05334

EXHIBIT DEATH

05334

1. Name of deceased: [illegible]  
2. Date of death: [illegible]  
3. Place of death: [illegible]  
4. Cause of death: [illegible]  
5. Name of physician: [illegible]  
6. Name of funeral home: [illegible]  
7. Name of next of kin: [illegible]  
8. Name of executor: [illegible]  
9. Name of attorney: [illegible]  
10. Name of witness: [illegible]  
11. Name of witness: [illegible]  
12. Name of witness: [illegible]  
13. Name of witness: [illegible]  
14. Name of witness: [illegible]  
15. Name of witness: [illegible]  
16. Name of witness: [illegible]  
17. Name of witness: [illegible]  
18. Name of witness: [illegible]  
19. Name of witness: [illegible]  
20. Name of witness: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
45M - 1

<div style="display: flex; justify-content: space-between;"> <span>02235</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>02231</span> </div> <div style="text-align: center; font-weight: bold;">CERTIFICATE OF DEATH</div>											
1. DECEASED-NAME (Type or print) <del>Kurt</del> <b>KURT HARRY BANDEMER</b>						2a. DATE OF DEATH February 11, 1969			2b. HOUR 6:30AM		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>6-14-85</b>			6. AGE (In years last birthday) <b>83</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Germany</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll County, Md.</b>					
10. CITY OR TOWN OF DEATH <b>Sykesville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) <b>Furniture Finisher</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Furniture</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. CITY OR TOWN <b>Balto. City</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>316 S. Fulton Avenue</b>		
14. FATHER'S NAME First Middle Last <b>William Bandemer</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Thelma</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>NO</b>				16b. SOCIAL SECURITY NO (If yes give year or dates of service) <b>None</b>		17. INFORMANT Address <b>Records, Springfield State Hospital</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral bronchopneumonia</b> <b>423x</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Heart failure, due to</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic adhesive pericarditis</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days</b>   <b>years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Involuntional psychotic reaction</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> ot work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>2-5-</b> , 19 <b>63</b> , to <b>2-11</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>2-11-1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Gloerito Sagisi</b>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>2-11-69</b>			
22d. PHYSICIAN'S NAME (Type) <b>Gloerito Sagisi, M.D.</b>						22e. ADDRESS <b>Springfield State Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>2-14-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Houdon Park</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE Md.</b>					
24. FUNERAL DIRECTOR <b>Geo. E. Schwab Funeral Home</b> <b>Francis W. Miller 2101 Fredrick Ave.</b>						25a. REC'D BY REGISTRAR DATE <b>13 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

10

—

111

—

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

<div style="display: flex; justify-content: space-between;"> <span>02236</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>02232</span> </div>									
1. DECEASED-NAME (Type or print) <b>ELIZABETH CATHERINE BECK</b>					2a. DATE OF DEATH Month <b>Feb.</b> Day <b>4</b> Year <b>1969</b>			2b. HOUR <b>10:00</b> AM	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>DEC. 31, 1872</b>		6. AGE (In years lost birthday) <b>96</b> YRS.		IF UNDER 1 YEAR MONTHS <b>96</b> DAYS <b>96</b> HOURS <b>96</b> MIN.	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL CO.</b> Md.			
10. CITY OR TOWN OF DEATH <b>WESTMINSTER</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>43 N. COLONIAL AVE</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSE-WIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b> COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>WESTMINSTER</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <b>43 N. COLONIAL AVE</b>			
14. FATHER'S NAME First <b>THOMAS</b> Middle <b>SINNOTT</b> Last <b>SINNOTT</b>				15. MOTHER'S MAIDEN NAME First <b>ANNE REBECCA</b> Middle <b>FROCK</b> Last <b>FROCK</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212-52-9186</b>		17. INFORMANT Address <b>SAME</b> <b>MRS KATERINE BECK, ADDRESS</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>465X upper respiratory illness</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>viral infection</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 or 4 days</b> <b>3 or 4 days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>2/12</b> , 19 <b>63</b> , to <b>2/4</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>2/1</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Julius Chopko</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>2/6/69</b>			
22d. PHYSICIAN'S NAME (Type) <b>Julius Chopko</b>				22e. ADDRESS <b>852 W. Green St Westmin.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>2/6/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. JOHNS CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>WESTMINSTER, MD.</b>			
24. FUNERAL DIRECTOR <b>2-2-Myers Jr, Westminster, Md.</b>				25a. REC'D BY REGISTRAR <b>FEB 7 1969</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

MEDICAL CERTIFICATION

THE STATE OF NEW YORK  
IN SENATE  
January 11, 1906.  
REPORT  
OF THE  
COMMISSIONER OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
MAY 1, 1905.  
ALBANY:  
J. B. LANE, PRINTERS.  
1906.



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## Items 1, 14, 17, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

### DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02233

1. DECEASED NAME (Type or Print) <b>WILLIAM CLINTON BOSTONIAN</b>		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>2</b> Day <b>11</b> Year <b>1969</b>		2b. HOUR <b>10:45</b> M	
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>AUG 12 - 1920</b>	6. AGE (In years last birthday) <b>48</b> YRS.	7. IF UNDER 1 YEAR: MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>WESTMINSTER</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>DOA CARROLL CO HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>KILN FEEDER</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>MARYLAND</b>		13b. COUNTY <b>FREDERICK</b>		13c. CITY OR TOWN <b>JOHNSVILLE</b>	
14. FATHER'S NAME: First <b>WILLIAM</b> Middle <b>H</b> Last <b>BOSTONIAN</b>		15. MOTHER'S MAIDEN NAME: First <b>MARY</b> Middle <b>GRIMM</b> Last <b>GRIMM</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	
16a. SOCIAL SECURITY NO. <b>215-14-1739</b>		17. INFORMANT <b>Boston</b>		ADDRESS <b>JOHNSVILLE MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thromboses</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>W Glenn Speicher</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>2-11-69</b>	
EXAMINER'S NAME (Type) <b>W GLENN SPEICHER</b>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ADDRESS <b>1335 E. Street, Westminister Carroll MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>FEB 14 - 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>METHODIST</b>	
24. FUNERAL DIRECTOR <b>D D Hartzler &amp; Sons</b>		ADDRESS <b>Union Bridge</b>		25a. REC'D BY REGISTRAR <b>FEB 17 1969</b>	
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

3333

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02238		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		02234	
Item 23 Film 409 2/26/69 kk		CERTIFICATE OF DEATH			
1. DECEASED-NAME (Type or print)		First Middle Last		2a. DATE OF DEATH	
Mamie		-		Branson	
3. SEX		4. RACE		5. DATE OF BIRTH	
female		Negro		6/2/82	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Maryland		USA		9. COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	
Rural--Sykesville		Springfield State Hospital		domestic	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN	
Md.		-		Baltimore	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
First Middle Last		First Middle Last		13e. STREET AND NUMBER	
Frank - Branson		Emily - Thomas		743 McCabe Avenue	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
no		218-52-1382		Springfield Hospital records, Sykesville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure					hours
437.9 DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Uremia					days
DUE TO, OR AS A CONSEQUENCE OF (c) Dehydration					days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic brain syndrome associated with cerebral arteriosclerosis with behavioral reaction.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (a) (this hospital) attended the deceased from 6/26/1968, to 2/7/1969, that (x) (we) last saw the deceased alive on 2/1/1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (a) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)	
Naci N. Buyukunsal, M. D.		2/7/69		Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		2/10/69		Mt Calvary Ch	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
J. S. Brown		DATE FEB 13 1969		Charles J. J. J.	

02281

02281

02235

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
45M - 1

1. DECEASED NAME (Type or print)						First						Middle						Last						2a. DATE OF DEATH						2b. HOUR											
						Month						Day						Year																							
3. SEX						4. RACE						5. DATE OF BIRTH						6. AGE (In years last birthday)						79 YRS.						IF UNDER 1 YEAR MONTHS DAYS						IF UNDER 24 HRS. HOURS MIN.					
Male						White						8-08-89																													
7a. BIRTHPLACE (State or foreign country)						7b. CITIZEN OF WHAT COUNTRY?						8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						9. COUNTY OF DEATH																							
Maryland						USA												Carroll																							
10. CITY OR TOWN OF DEATH						11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)						12b. KIND OF BUSINESS OR INDUSTRY																							
Rural						Springfield State Hosp.						Laborer/retired						Can Continental																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE						13b. COUNTY						13c. CITY OR TOWN						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>						13e. STREET AND NUMBER																	
Maryland												Baltimore						YES <input type="checkbox"/> NO <input type="checkbox"/>						5016 Edg ar Terrace																	
14. FATHER'S NAME First Middle Last						15. MOTHER'S MAIDEN NAME First Middle Last																																			
Unknown						Unknown																																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown						16b. SOCIAL SECURITY NO.						17. INFORMANT Address Md.																													
No						215-01-6523						Springfield State Hosp. records, Sykesville,																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Pneumonia</u> <u>4123</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic Heart Disease</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>months</u> <u>years</u>																																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)						21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work						21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)						21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from <u>4-8</u> , 19 <u>63</u> , to <u>2-23</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2-23</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																									
22b. SIGNATURE <u>Gracito V. Patricio</u>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED <u>2/23/69</u>																													
22d. PHYSICIAN'S NAME (Type) <u>Gracito Patricio</u>						22e. ADDRESS <u>Springfield State Hospital, Sykesville, MD</u>																																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						23b. DATE <u>2-26-69</u>						23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>						23d. LOCATION (City or Town) (County) (State) <u>Balto - Md</u>																							
24. FUNERAL DIRECTOR <u>H. L. ...</u>						ADDRESS <u>3218 Madison St.</u>						25a. REC'D BY REGISTRAR DATE <u>FEB 25 1969</u>						25b. REGISTRAR'S SIGNATURE <u>f Charles Judge</u>																							

500 500



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>02240</p> <p>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p><b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b></p> </div> <div> <p>02236</p> <p>00 06 1</p> </div> </div>											
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>CARROLL</u> MARYLAND</p> <p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Union Mills</u></p> <p>c. LENGTH OF STAY IN 1b</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>R # 2 Westminster, Md.</u></p>					<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</p> <p>a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u></p> <p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster (Union Mills)</u></p> <p>d. STREET ADDRESS <u>Route # 2</u></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/></p>						
<p>3. NAME OF DECEASED (Type or print) <u>CASS</u> First Middle Last</p>					<p>4. DATE OF DEATH <u>Feb. 19 1969</u> Day Month Year</p>						
<p>5. SEX <u>Male</u></p>		<p>6. COLOR OR RACE <u>White</u></p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>Jan. 18, 1898</u></p>		<p>9. AGE (In years last birthday) <u>71</u> yrs.</p>		<p>IF UNDER 1 YEAR Months Days</p> <p>IF UNDER 24 HRS. Hours Min.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u></p>				<p>10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u></p>				<p>11. BIRTHPLACE (State or foreign country) <u>Tennessee</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>	
<p>13. FATHER'S NAME <u>Charlie Bunch</u></p>					<p>14. MOTHER'S MAIDEN NAME <u>Emily Lou Gibson</u></p>						
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)</p>				<p>16. SOCIAL SECURITY NO. <u>414-16-3311</u></p>		<p>17. INFORMANT <u>Howard Bunch, Westminster, Maryland 21157</u> Address</p>					
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Cardiac Infarction</u></p> <p>4109 DUE TO (b) <u>Arterio Sclerotic C-V Disease</u></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p>										<p>INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u></p>	
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/></p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>							
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19</p>				<p>20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work</p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>			
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/></p>											
<p>ACTUAL SIGNATURE <u>Maurice C. Porterfield</u> M.D.</p>						<p>22. DATE SIGNED <u>MARCH 2-19-69</u></p>					
<p>EXAMINER'S NAME (Type) <u>M.C. PORTERFIELD</u></p>						<p>ADDRESS (Street, city, town, or county) <u>HAMPSTEAD, MD</u></p>					
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>			<p>23b. DATE THEREOF <u>2/23/69</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <u>Lady Collins Cemetery</u></p>			<p>23d. LOCATION (City, town or county) (State) <u>Sneedville, Tennessee</u></p>			
<p>24. FUNERAL DIRECTOR <u>C.O. Fuss &amp; Son</u></p>						<p>ADDRESS <u>Taneytown, Maryland</u></p>			<p>25a. REC'D BY REGISTRAR <u>FEB 21 1969</u> OATE</p>		
						<p>25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u></p>					

FOR SALE  
NEW YORK

AD-10-27

AD-10-27

WILSON, FRANKLIN, 1000 10TH ST. N.W., WASHINGTON, D.C.

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

AD-10-27

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-69

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <b>EMMA</b>				First <b>B.</b> Middle <b>COHEN</b> Last				2a. DATE OF DEATH <b>Feb</b> Month <b>21</b> Day <b>1969</b> Year			2b. HOUR <b>4:30</b> M
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>AUGUST 5, 1910</b>			6. AGE (In years last birthday) <b>58</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>
7a. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL</b> Md.					
10. CITY OR TOWN OF DEATH <b>WESTMINSTER</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>CARROLL COUNTY GENERAL HOSP.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>WESTMINSTER</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>133 WASHINGTON ROAD</b>		
14. FATHER'S NAME First <b>JOSEPH</b> Middle <b>BIORSKI</b> Last				15. MOTHER'S MAIDEN NAME First <b>FANNIE</b> Middle <b>KANINSKY</b> Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown				16b. SOCIAL SECURITY NO. <b></b>		17. INFORMANT <b>MR. LOUIS COHEN, 133 WASHINGTON ROAD, WESTMINSTER, MD. 21157</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>4460</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diffuse vasculitis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Pericarditis nodosa</b>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec</b> , 19 <b>62</b> to <b>Feb 21</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>Feb 21</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>John S. Harshey, MD</b>						DEGREE <b></b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>2/21/69</b>			
22d. PHYSICIAN'S NAME (Type) <b>JOHN S. HARSHEY, MD</b>						22e. ADDRESS <b>8 Anchor St. Westminster, Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>2-23-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BETH JACOB</b>		23d. LOCATION (City or Town) (County) (State) <b>FINKSBURG, MARYLAND</b>					
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>						25a. REC'D BY REGISTRAR DATE <b>FEB 26 1969</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MEDICAL CERTIFICATION

02261

02261

OFFICE OF DEATH

REGISTERED WITH STATE OF NEW YORK

NAME

WHITE

1910

DEPT

EDUC

REGISTERED

CENTRAL COUNTY GENERAL HOSP

IN

REGISTERED

REGISTERED

1910

DEPT

EDUC

DEPT

1910

DEPT. OF HEALTH, NEW YORK

NEW YORK

NEW YORK

1910

1910

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A12  
30M REV.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
IDA MYERS ENGLAR						Feb. Month 22 Day 1969 Year			3:15 am
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS
F		W		DEC 27- 1868			100 YRS.		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		USA				CARROLL Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
MIDDLEBURG			BROOKFIELD NURSING HOME			HOUSEKEEPER		OWN HOME	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
STATE MARYLAND			CARROLL		UNIONTOWN		YES		NONE
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last DAVIS MYERS			First Middle Last REBECCA GEIMAN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
NO			213-12-7753		HILDA SPEICHER, UNIONTOWN MD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Generalized Atherosclerosis									Years
4409 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1964, 19, to Now, 19, that (I) (we) lost saw the deceased alive on Feb 21 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE J. H. CARICOFF MD DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								22c. DATE SIGNED Feb 22, 1969	
22d. PHYSICIAN'S NAME (Type) J. H. CARICOFF								22e. ADDRESS UNION BRIDGE MD	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		2/24/69		PIPE CREEK		UNIONTOWN RURAL CARROLL MD			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE	
W. D. Hartzler & Sons				New Windsor		FEB 25 1969		J. H. Caricoff	

81380

NOV 10 1963

81380

NOV 10 1963



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

02243				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				02239					
1. DECEASED-NAME (Type or print)				First Middle Last				2a. DATE OF DEATH				2b. HOUR	
Loma				Leo				Gist				Month Feb Day 20 Year 69 2:15 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		2-6-1889				80 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						Md.	
Cambridge		USA				Carroll							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY	
Manchester, Md.				128 W. Main St. Longview Nursing Home				Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Md.				Carroll		Finksburg		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RFD # 2			
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last									
William Hubbard				Marie Asplen									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT (SON)				Address			
NO				218-46-4884		Woodrow Gist				Prestonsburg Md. RFD # 3			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis												36 hrs	
4124 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic C.V. Disease												years	
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
Carcinoma of left breast.													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (1) (this hospital) attended the deceased from Feb. 13, 1969, to Feb. 20, 1969, that (1) (we) last saw the deceased alive on Feb. 19, 1969, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.													
22b. SIGNATURE				DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
Mamie C. Porterfield										Feb. 20, 1969			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS									
M.C. PORTERFIELD				HAMPSTEAD, MD									
23. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Burial				2/24/69		FINKSBURG CHURCH Cem.				FINKSBURG MD.			
24. FUNERAL DIRECTOR				ADDRESS				25a. RECEIVED REGISTRAR		25b. REGISTRAR'S SIGNATURE			
J. S. Myers Jr.				Westminster, Md.				FEB 24 1969					

03330

03330

03330

Hubbard

03330

Hubbard

03330

03330

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) <i>Estelle M. Hosnell</i>						2a. DATE OF DEATH Month <i>2</i> Day <i>26</i> Year <i>69</i>			2b. HOUR <i>4 P M</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>Oct-22-1884</i>			6. AGE (In years last birthday) <i>84</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Carroll Co Maryland Md</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Carroll.</i> Md.						
10. CITY OR TOWN OF DEATH <i>128 W. Main St. Manchester, Md.</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Longview Nursing Home.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institutional: Residence before admission) STATE <i>Md</i>			13b. COUNTY <i>Carroll.</i>		13c. CITY OR TOWN <i>Woodbine Md.</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>Route #1 21979.</i>			
14. FATHER'S NAME First <i>Leri</i> Middle <i>D.</i> Last <i>Frygell</i>				15. MOTHER'S MAIDEN NAME First <i>Virginia</i> Middle <i>Albert</i> Last <i>(son)</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>no.</i>		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>220-01-1844A</i>		17. INFORMANT Address <i>Albert Hosnell Woodbine Md. Rte #1</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular accident</i> <i>4123</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i> <i>3 yrs</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from <i>1/29</i> , 19 <i>68</i> , to <i>2/26</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>2/26</i> , 19 <i>69</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>W H Foward M.D.</i> DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>2/26/69</i>				
22d. PHYSICIAN'S NAME (Type) <i>W. H Foward M.D.</i>						22e. ADDRESS <i>Manchester, Md 21102</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3/1/1969</i>		23c. NAME OF CEMETERY OR CREMATOR <i>Ebenezer</i>		23d. LOCATION (City or Town) (County) (State) <i>Winfield, Carroll, Md.</i>						
24. FUNERAL DIRECTOR ADDRESS <i>C.M. Waltz, Box 241, Sykesville, Md.</i>						25a. REC'D BY REGISTRAR <i>MAR 3 1969</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

01000

RECEIVED

01000

CONFIDENTIAL  
This document contains information that is exempt from public release under the Freedom of Information Act, 5 U.S.C. 552, and is to be controlled, stored, handled, transmitted, and disposed of in accordance with the provisions of the Department of Defense Information Security Manual, 100-20, and the Department of Defense Information Security Manual, 100-20, and the Department of Defense Information Security Manual, 100-20.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02245		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		02241			
Item 6 Film 409 2/13/69 kk							
1. DECEASED-NAME (Type or print)			First Middle Last		2a. DATE OF DEATH		
Mary			GRAVESON		Feb. 2 1969 2:55 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	
Female		White		2-14-1882		86 2/3 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
N.Y.		U.S.A.		CARROLL		Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Sykesville		Springfield State Hosp.		Housewife			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MARYLAND		City		Baltimore		2927 Harford Rd.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.	
Christian		Johnson		Christina Hanson		218522218T	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Hospital Records.		4379 Branding pneumonia		Days.			
		generalized arteriosclerosis.		Years.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)		COPD associated with cerebral arteriosclerosis.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (X) (this hospital) attended the deceased from 10-30-1968, to 2-2-1969, that (X) (we) last saw the deceased alive on 2-2-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED			
Suha Ozgun.		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		2-2-69			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	
Suha Ozgun		Springfield State Hospital Sykesville Md.		Burial		2/8/69	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR	
Sleepy Hollow		Tarrytown New York		Leonard J Ruck Inc Baltimore, Maryland		DATE FEB 7 1969	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE					
Charles Judge							

1000

1000

1000

1000

1000

1000

1000

1000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last <b>DELBERT EARL GREEN</b>						2a. DATE OF DEATH Month Day Year <b>7-9-1969</b>			2b. HOUR <b>8:45</b> M		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>APRIL 7, 1886</b>			6. AGE (In years last birthday) <b>82</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.-B.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL CO.</b> Md.					
10. CITY OR TOWN OF DEATH <b>WESTMINSTER</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>STONE ROAD</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>FARMER</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>				13b. COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>WESTMINSTER</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>RFD#7 STONE RD.</b>	
14. FATHER'S NAME First Middle Last <b>AARON GREEN</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>ANNA LOWE</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>THEO. H. GREEN, SAME ADDRESS</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Uremia</b> <b>600X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Prostatic Hypertrophy &amp; Hemorrhagic cystitis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4-6 weeks</b> <b>Unknown</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>Chronic Bronchitis</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 8</b> , 19 <b>69</b> , to <b>Feb 9</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>Feb 9</b> , 19 <b>69</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>M.C. Porterfield, M.D.</b>						22c. DATE SIGNED <b>2-10-69</b>					
22d. PHYSICIAN'S NAME (Type) <b>M.C. Porterfield, M.D.</b>						22e. ADDRESS <b>Hampstead, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>2/12/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. PLEASANT CEMETERY GAMBER CARROLL, MD.</b>				23d. LOCATION (City or Town) (County) (State) <b>CARROLL, MD.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>J. S. Myers, Jr., Westminster, Md.</b>						25a. REC'D BY REGISTRAR <b>DATE FEB 13 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

85343

85343

(M)

(1)

US-101-101

WAVE 1

WAVE 1

WAVE 2

WAVE 2

WAVE 3

WAVE 3

WAVE 4

WAVE 4

WAVE 5

WAVE 5

WAVE 6

WAVE 7

WAVE 7

WAVE 8

WAVE 9

WAVE 10

WAVE 11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (11-59)  
30M REV. 1-59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02247		02243	
1. DECEASED-NAME (Type or print) <b>STANLEY AMBROSE HAHN</b>		2a. DATE OF DEATH Month <b>2</b> Day <b>11</b> Year <b>1969</b>	
3. SEX <b>Male</b>		2b. HOUR <b>5:45 AM</b>	
4. RACE <b>White</b>		5. DATE OF BIRTH <b>11-22-1894</b>	
6. AGE (In years last birthday) <b>74</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b> Md.	
10. CITY OR TOWN OF DEATH <b>Sykesville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hosp. Electrician</b>	
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b> COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Smithburg</b>	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Route 2</b>	
14. FATHER'S NAME First <b>William</b> Middle <b>Hahn</b> Last		15. MOTHER'S MAIDEN NAME First <b>Hattie</b> Middle <b>Wetzel</b> Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>217-10-9527</b>	
17. INFORMANT <b>Records, Springfield State Hospital</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> <b>4124</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Chronic Bronchitis syndrome 206 Arteriosclerosis</b>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>6-21-66</b> , 19 <b>66</b> , to <b>2-11</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>2-11-69</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Glocrite G. Sagisi, M.D.</b> DEGREE <b>M.D.</b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>2-11-69</b>	
22d. PHYSICIAN'S NAME (Type) <b>Glocrite G. Sagisi, M.D.</b>		22e. ADDRESS <b>Springfield St. Hosp., Sykesville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2/13/1969</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Lantz #1, Frederick Co., Md.</b>	
24. FUNERAL DIRECTOR <b>Harold G. Carr</b> ADDRESS <b>Waynesboro, Penna.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 13 1969</b>	
25b. REGISTRAR'S SIGNATURE <b>James Judge</b>			

MEDICAL CERTIFICATION

5425

1980

100

\_\_\_\_\_

1

2021.11.11

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 500  
30M REV 1/65

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <i>Andrew B. Harryman</i>						2a. DATE OF DEATH <i>Feb</i> Month <i>14</i> Day <i>1969</i> Year			2b. HOUR <i>7:10</i> M		
3. SEX <i>FEMALE</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>February 9, 1913</i>			6. AGE (In years last birthday) <i>56</i> YRS.		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Carroll County</i> Md.					
10. CITY OR TOWN OF DEATH <i>Westminster</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Carroll Co. Hosp.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Clerical</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Hospital</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Carroll</i>		13c. CITY OR TOWN <i>Westminster</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>RD 2 Box 354</i>		13f. <i>Westminster</i> Md.
14. FATHER'S NAME First <i>Joshua</i> Middle <i>T.</i> Last <i>Harryman</i>				15. MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>Feig</i> Last <i>Feig</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address <i>21208 Mr. Clifton W. Harryman 4219 Milford Mill Rd.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>ASCVD.</i> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <i>July</i> , 19 <i>69</i> , to <i>Feb</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>Feb 9</i> , 19 <i>69</i> , and that in my(our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Dean J. Enuff M.D.</i> DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>14 Feb 69</i>			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS <i>19 Ridge Rd., Westminster, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>2/18/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge Cemetery</i>		23d. LOCATION (City or Town) <i>Pikesville, Md.</i> (County) <i>Balto Co.</i> (State)					
24. FUNERAL DIRECTOR <i>McCully F. H.</i> ADDRESS <i>237 Patapsco Ave. 21225</i>						25a. REC'D BY REGISTRAR <i>FEB 17 1969</i> DATE		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION

14321

14321

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 10/10/01 BY 60322 UCBAW/STP



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH MATED			2b. HOUR
Lilly (NMN) Hicks						2-26-69 19			M
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	OAYS	IF UNDER 24 HRS. HOURS	MIN.	2c. DATE PRONOUNCED DEAD Month	2d. HOUR
Female	Negro	1895?	74? YRS.					2- Day 26- Year 69	2:10P M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Georgia		U.S.A.		Carroll County, Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Sykesville			Springfield State Hospital						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER			
Maryland			Balto. City		Baltimore	1703 McCulloh Street			
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
William Williams			Elizabeth						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
					Records, Springfield State Hospital				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, bilateral</u> 485X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Fracture, right femur.</u> <u>CBS, with cerebral arteriosclerosis with behavioral reaction</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			2-26-69			
W. Glenn Speicher, M.D.			ADDRESS Street or R.F.D. No.			135 E. Main St. Carroll			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County)		
			3/4/69		Mt Calvary Cemetery		A A County Md		
24. FUNERAL DIRECTOR ADDRESS					25a. RECEIVED BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE		
Adolphus Halstead 1206 W North Ave					FEB 28 1969		Charles Judge		

34330

34330

FEB 2 1966

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-65

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
02250						CERTIFICATE OF DEATH			02246				
1. DECEASED-NAME (Type or print)				First		Middle		Last		2a. DATE OF DEATH Month Day Year			
Frederick				NMN		Jones		2			17 69		
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male		Negro		8-7-12				36 YRS.					
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Pennsylvania				USA				Carroll County Md.					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Sykesville, Md.				Springfield St. Hosp.				Laborer		unk.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Md.				Montgomery		Bethesda		YES		7010 Thor Lane			
14. FATHER'S NAME				First		Middle		Last		15. MOTHER'S MAIDEN NAME			
William				unk.		Evans		?		? Hughes			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address							
no				212-14-5827		Records, Springfield S.H., Sykesville, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Acute congestive heart failure													
4122 DUE TO, OR AS A CONSEQUENCE OF													
(b) Hypertensive cardiovascular disease													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic brain syndrome associated with central nervous system syphilis, meningoen-													
encephalitis with psychotic reaction.													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
none													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
				19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from May 12, 1965, to February 17, 1969, that (I) (we) lost saw the deceased alive on Feb. 17, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE								DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED	
Irfan Esendal, M.D.												2-17-69	
22d. PHYSICIAN'S NAME (Type)								22e. ADDRESS					
Irfan Esendal, M.D.								Springfield State Hospital, Sykesville					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Burial				2-23-69		Lincoln Park.,				Rockville, Md.			
24. FUNERAL DIRECTOR								ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
George R. Snowden								Rockville		FEB 26 1969		Charles Judge	

0550

RECEIVED

0550

0550

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02251

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02247

1. DECEASED-NAME (Type or Print) <b>JOHN MICHAEL KEMP</b>			2a. DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> <b>2 25 1969</b>			2b. HOUR M <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> <b>8:50</b>		
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>6-3-49</b>	6. AGE (In years last birthday) <b>19</b> YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> <b>February, 25, 1969</b>		
7a. BIRTHPLACE (State or foreign country) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b> Md.		
10. CITY OR TOWN OF DEATH <b>Sykesville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Student</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>2330 Appletree Drive</b>			14. FATHER'S NAME First Middle Last <b>John H. Kemp</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Dorothy Swancott</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16b. SOCIAL SECURITY NO. <b>246-06-5711</b>		17. INFORMANT ADDRESS <b>Records, Springfield State Hospital</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>485X</b> IMMEDIATE CAUSE (a) <b>Confluent bronchopneumonia, left lung and posterior part of right lung</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>CBS assoc. with convulsive disorder, with behavioral reaction</b>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, form, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County
						State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>W. Glenn Speicher</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>2-25-69</b>		
EXAMINER'S NAME (Type) <b>W. Glenn Speicher, M.D.</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Charles J. Judge</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>2/28/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL</b>		23d. LOCATION (City or Town) (County) <b>HAGERSTOWN WASH.</b>		
24. FUNERAL DIRECTOR <b>W. T. Norrunt</b>				ADDRESS <b>RT 45 Hwy</b>		25a. REC'D BY REGISTRAR <b>MAR 4 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

02847

RECEIVED BY USA

02847

02847

1972-11-14

1972-11-14

1972-11-14

1972-11-14

1972-11-14

1972-11-14

1972-11-14

1972-11-14

1972-11-14

1972-11-14

1972-11-14

1972-11-14

1972-11-14

1972-11-14

1972-11-14

1972-11-14

1972-11-14

1972-11-14

1972-11-14

1972-11-14

1972-11-14

1972-11-14

1972-11-14

1972-11-14



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15  
30M REV. 1-66

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <b>GEORGE JOHN KREIT</b>			2a. DATE OF DEATH Month <b>FEB</b> Day <b>5</b> Year <b>1969</b>			2b. HOUR <b>12:00</b> AM					
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>JUNE 18 1887</b>		6. AGE (In years last birthday) <b>81</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL</b> Md.					
10. CITY OR TOWN OF DEATH <b>RFD WESTMINSTER</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ROUTE #7</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>FARMING</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>MARYLAND</b> STATE			13b. COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>WESTMINSTER</b>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>RFD #7</b>		
14. FATHER'S NAME First <b>JOHN</b> Middle <b>KREIT</b> Last			15. MOTHER'S MAIDEN NAME First <b>KATHERINE</b> Middle <b>RAU</b> Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <b>NO</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NUMBER <b>314988620</b>			16c. NAME OF NEXT OF KIN <b>GEORGE KREIT JR. (SON)</b> <b>WESTMINSTER MARYLAND</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CONGESTIVE HEART FAILURE 9 YEARS</b> <b>491X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>EMPHYSEMA-CHRONIC BRONCHITIS 9 YEARS</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>JANUARY 61</b> , to <b>FEBRUARY 69</b> , that (I) (we) last saw the deceased alive on <b>FEB 5</b> 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Daniel I. Welliver M.D.</b>						22c. DATE SIGNED <b>2-5-69</b>					
22d. PHYSICIAN'S NAME (Type) <b>DANIEL I. WELLIVER MD.</b>						22e. ADDRESS <b>19 RIDGE ROAD WESTMINSTER MARYLAND</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>2/8/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cem.</b>			23d. LOCATION (City or Town) (County) (State) <b>Belts Md.</b>			
24. FUNERAL DIRECTOR <b>Strohn F. Inc.</b>						25a. REC'D BY REGISTRAR DATE <b>FEB 6 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

84330

84330

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <i>Maurice</i>			First <i>D.</i> Middle <i>Larkins</i> Last			2a. DATE OF DEATH Month <i>2</i> Day <i>15</i> Year <i>69</i>			2b. HOUR <i>4:30 PM</i>		
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>March 13, 1905</i>			6. AGE (In years last birthday) <i>63</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <i>Balto. Co.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Carroll</i> Md.					
10. CITY OR TOWN OF DEATH <i>Westminster</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Carroll Co. Gen. Hospt.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Supervisor at Sagnore Farms</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Owings Mills</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>Park Heights Ave.</i>		
14. FATHER'S NAME First <i>Charles</i> Middle <i>T.</i> Last <i>Larkins</i>			15. MOTHER'S MAIDEN NAME First <i>Carrie</i> Middle <i>Belt</i> Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown			16b. SOCIAL SECURITY NO. <i>216-05-5248</i>		17. INFORMANT <i>Mr. C. William Larkins</i>				Address <i>Owings Mills, Md.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ACUTE MYOCARDIAL INFARCTION</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ATHEROSCLEROTIC CORONARY</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>HEART DISEASE</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 WEEK</i>  <i>YEARS</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>2/7</i> , 19 <i>69</i> , to <i>2/15</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>2/15</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Virgilio J. Brown MD</i>						22c. DATE SIGNED <i>2/15/69</i>					
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <i>Feb. 18, 69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge</i>		23d. LOCATION (City or Town) (County) (State) <i>Pikesville, Md.</i>				
24. FUNERAL DIRECTOR <i>J. F. Eline &amp; Sons</i>						ADDRESS <i>Reisterstown, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>FEB 17 1969</i>		25b. REGISTRAR'S SIGNATURE <i>William J. Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) First Middle Last <b>Raymond Benjamin Lowe</b>					2a. DATE OF DEATH Month Day Year <b>2 6 69</b>			2b. HOUR <b>9:05 PM</b>		
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>9-1-89</b>		6. AGE (In years last birthday) <b>79</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b> Md.				
10. CITY OR TOWN OF DEATH <b>Sykesville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Keedysville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>None</b>	
14. FATHER'S NAME First Middle Last <b>Benjamin NMN Lowe</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Susan Elizabeth Snyder</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16b. SOCIAL SECURITY NO. <b>215-26-1295</b>		17. INFORMANT Address <b>Hospital records</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>437.9</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>years</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>CBS assoc. with cerebral arteriosclerosis without qualifying phrase</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>6/7</b> , 19 <b>66</b> , to <b>2/6</b> , 19 <b>69</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>2/6</b> , 19 <b>69</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (did not) view the body after death.										
22b. SIGNATURE <b>Suha Ozgun</b>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>2/6/69</b>			
22d. PHYSICIAN'S NAME (Type) <b>Suha Ozgun, M.D.</b>					22e. ADDRESS <b>Springfield State Hospital, Sykesville, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>2-9-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bakersville Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Bakersville, Wash. Co., Md.</b>				
24. FUNERAL DIRECTOR ADDRESS <b>John H. Bast, Jr. 112 N. Main Street, Boonshoro, Md.</b>					25a. REC'D BY REGISTRAR <b>FEB 10 1969</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

02820

02820

02820

2-2-59 Bakerville Cemetery Bakerville, Ark. Co., Mo.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02255 Elizabetha		02251	
1. DECEASED-NAME (Type or print) First Middle Last Elizabeth Theresa Luers		2a. DATE OF DEATH Month Day Year 2 5 69	
3. SEX Female	4. RACE White	5. DATE OF BIRTH 7-26-1877	6. AGE (In years last birthday) 91 YRS.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Carroll
10. CITY OR TOWN OF DEATH Rural--Sykesville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Carroll	13c. CITY OR TOWN Sykesville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First Middle Last Adam Buchheit	15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth ? ?	17. STREET AND NUMBER Liberty Rd. & Oakland Mill Rd.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown <input type="checkbox"/> (If yes give war or dates of service)	16b. SOCIAL SECURITY NO. 218-52-0588	17. Joseph Luers - 3 Cedar Hill Road Springfield Hospital records, Sykesville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 4123 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Day Years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Chronic brain syndrome associated with senile brain disease without qualifying phrase.</u>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (this hospital) attended the deceased from <u>9/29/1965</u> , to <u>2/5/1969</u> , that (we) last saw the deceased alive on <u>2/5/1969</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death.			
22b. SIGNATURE <u>Francisco J. Ceballos, MD</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED 2/5/69
22d. PHYSICIAN'S NAME (Type) Francisco J. Ceballos, M. D.		22e. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2-8-69	23c. NAME OF CEMETERY OR CREMATORY Holy Family Cemetery	23d. LOCATION (City or Town) (County) (State) Randallstown, Maryland
24. FUNERAL DIRECTOR Marion Armacost-4600 Liberty Hghts. Ave		25a. REC'D BY REGISTRAR DATE FEB 11 1969	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

2324

5.

[2] J. L. Lagarias, *The distribution of totients*, *J. Number Theory* **96** (2003), no. 2, 225–248.

AC 11 11 50 - 700 11

[illegible]

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give (Pages), 2, and 10 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form "PMR" Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or Print) <i>Hilda May Miller</i>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month <i>2</i> Day <i>18</i> Year <i>1969</i>			2b. HOUR <i>3 P.M.</i>			2c. DATE PRONOUNCED DEAD Month <i>2</i> Day <i>18</i> Year <i>1969</i>			2d. HOUR <i>4 P.M.</i>			
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>JULY 26 1900</i>		6. AGE (In years last birthday) <i>68</i> YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN. _____					
7a. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>				7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <i>Carroll</i> Md.			
10. CITY OR TOWN OF DEATH <i>WESTMINSTER</i>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>64 So. COLONIAL AVE</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>OPERATOR CLOTHING FACTORY</i>				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MARYLAND</i> COUNTY <i>CARROLL</i>				13c. CITY OR TOWN <i>WESTMINSTER</i>				13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				13e. STREET AND NUMBER <i>60 So. COLONIAL AVE</i>			
14. FATHER'S NAME <i>JAMES EDWARD DAVIS</i>				15. MOTHER'S MAIDEN NAME <i>MARY ELIZABETH SHUEY</i>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>				16b. SOCIAL SECURITY NO. <i>213-05-3781</i>				17. INFORMANT <i>THORNTON A. DAVIS</i>				ADDRESS <i>EAST CHURCH ST. FREDERICK, MD.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterio-sclerosis - Cerebral</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Genes.</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Instant</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. <i>19</i>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <i>M.C. Porter Field</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)				22b. DATE SIGNED <i>2-18-69</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>				23b. DATE <i>2/21/69</i>				23c. NAME OF CEMETERY OR CREMATORY <i>MEADOW BRANCH CEMETERY WESTMINSTER, MD.</i>				23d. LOCATION (City or Town) (County) (State) <i>WESTMINSTER, MD.</i>			
24. FUNERAL DIRECTOR <i>R.S. Moore, Jr. Westminster, Md.</i>				ADDRESS				25a. REC'D BY REGISTRAR DATE <i>FEB 21 1969</i>				25b. REGISTRAR'S SIGNATURE <i>W. Chomley</i>			

Richard J. H. Meadows Branch - 10000  
Feb 21 1902

James Edward Davis Mary Elizabeth  
212-227th Tenthon A Davis, Frederick

WESTIN 1877  
MAY 18 1877

May 18 1877

02252  
02252

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15  
30M REV. 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
02257		CERTIFICATE OF DEATH						02253			
1. DECEASED-NAME (Type or print) First Middle Last <b>WALTER WILLIAM MILLER</b>						2a. DATE OF DEATH Month Day Year <b>2 23 1969</b>				2b. HOUR <b>6:12 P.M.</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>JULY 19, 1887</b>		6. AGE (In years last birthday) YRS. <b>81</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL Co.</b>				Md.	
10. CITY OR TOWN OF DEATH <b>FINKSBURG</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>RT #1</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>FARMER</b>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>FINKSBURG</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>RT #1</b>			
14. FATHER'S NAME First Middle Last <b>PETER MILLER</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>?</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>217-36-4868</b>		17. INFORMANT Address <b>CHAS. H. MILLER WESTMINSTER RT #4 Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>coronary occlusion</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) <b>arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b> <b>noticed past year</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>none</b>											
19a. DATE OF OPERATION <b>none</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>none</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>none</b>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>Aug. 11, 1968</b> , to <b>Feb. 23, 1969</b> , that (I) (we) last saw the deceased alive on <b>Feb. 20, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>C. L. Billingslea M.D.</b>		22c. DATE SIGNED <b>2-24-69</b>		22d. PHYSICIAN'S NAME (Type) <b>C. L. Billingslea, M.D.</b>		22e. ADDRESS <b>Westminster, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>2/26/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>TRINITY LUTH. CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>FINKSBURG RD. MD</b>					
24. FUNERAL DIRECTOR <b>J. E. Myers, Jr. Westminster, Md.</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 28 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							

MEDICAL CERTIFICATION

05523

05523

05523

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First ANNA			Middle (NMN)			Last MORAVEC		
3. SEX Female			4. RACE White			5. DATE OF BIRTH 4-20-1884			2a. DATE OF DEATH Month Day Year FEBRUARY 13, 1969		
7a. BIRTHPLACE (State or foreign country) Czechoslovakia			7b. CITIZEN OF WHAT COUNTRY? Alien			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Carroll Md.		
10. CITY OR TOWN OF DEATH Sykesville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. CITY OR TOWN Montgomery			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13d. STREET AND NUMBER 2410 Hayden Drive		
14. FATHER'S NAME First Middle Last Joseph Opocenskeho			15. MOTHER'S MAIDEN NAME First Middle Last Anna Unk.			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No			16b. SOCIAL SECURITY NO. ---		
17. INFORMANT Address Records, Springfield State Hospital			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Years			PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Pulmonary emphysema					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 6-8-66, 19__, to 2-13-69, 19__, that (I) (we) last saw the deceased alive on 2-13-69, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Agustin del Campo, M.D.						22c. DATE SIGNED 2-13-69					
22d. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.						22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21784					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 2-17-69			23c. NAME OF CEMETERY OR CREMATORY Bohemian Nat. Cemetery			23d. LOCATION (City or Town) (County) (State) Chicago Ill.		
24. FUNERAL DIRECTOR Thurg W Haight						25a. REC'D BY REGISTRAR FEB 17 1969			25b. REGISTRAR'S SIGNATURE		

03828

03828

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-69

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <b>Catherine A. Mullen</b>					2a. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>10</b> Year <b>1969</b>			2b. HOUR <b>11 A. M.</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>DEC. 3, 1880</b>			6. AGE (In years last birthday) <b>88</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.		
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL</b> Md.					
10. CITY OR TOWN OF DEATH <b>DUNKESVILLE</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GOLDEN AGE CONV. HOME</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13d. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b> COUNTY <b>BALTIMORE</b>			13c. CITY OR TOWN <b>DUNDALK</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>9 YORKWAY</b>				
14. FATHER'S NAME First <b>GUSTAV</b> Middle <b>BROWN</b> Last <b>BROWN</b>				15. MOTHER'S MAIDEN NAME First <b>ANNA E.</b> Middle <b>FROST</b> Last <b>FROST</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>242-70588D</b>		17. INFORMANT <b>JOHN R. BROWN</b>			Address <b>SAME AS #13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio sclerotic heart disease</b>										<b>1 year</b>	
4123 DUE TO, OR AS A CONSEQUENCE OF <b>Coronary artery disease</b>										<b>?</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. <b>19</b> Month <b>11</b> Day <b>10</b> Year <b>1969</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. <b>1226 S. Hanover Street</b> City or Town <b>BALTIMORE</b> County <b>MARYLAND</b> State <b>MARYLAND</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov. 16, 1968</b> to <b>Feb 10, 1969</b> , that (I) (we) lost the deceased on <b>Feb 8, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Harry Deibel M.D.</b> PHYSICIAN <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								22c. DATE SIGNED <b>2/11/69</b>			
22d. PHYSICIAN'S NAME (Type) <b>Harry Deibel M.D.</b>						22e. ADDRESS <b>1226 S. Hanover Street</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>FEB. 13, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK CEMETERY</b>			23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>			
24. FUNERAL DIRECTOR <b>WALTER BROOKS BRADLEY, INC.</b> ADDRESS <b>DUNDALK, MD.</b>						25a. REC'D BY REGISTRAR <b>FEB 13 1969</b>		25b. REGISTRAR'S SIGNATURE <b>John R. Brown</b>			

MEDICAL CERTIFICATION

02350

RECEIVED

02350

A. Miller

Cashier

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div>02260</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>02256</div>																	
1. DECEASED-NAME (Type or Print)						First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR					
LEWIS LOUIS ELDON MUNCH									Month Day Year 2/19 1969			M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR		
Male		White		Aug. 25, 1912		56 YRS.		MONTHS DAYS		HOURS MIN		Month Day Year February 19, 1969			P.M.		
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH					
W. Virginia				U.S.A.								CARROLL Md.					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY					
Westminster				Manchester Avenue				Restaurant owner & operator									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Md.				CARROLL				Westminster				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		184 William Avenue			
14. FATHER'S NAME First Middle Last						15. MOTHER'S MAIDEN NAME First Middle Last											
Edgar Eldon Munch						Elizabeth Dent											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16b. SOCIAL SECURITY NO.						17. INFORMANT ADDRESS					
no						234-01-1938						Mrs. Charlotte S. Munch, William Ave. Westminster, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) Hypertensive and arteriosclerotic cardiovascular disease																	
DUE TO, OR AS A CONSEQUENCE OF																	
(b)																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?					
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
CAUSE OF DEATH				P.M. 19													
21d. INJURY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.				City or Town County State					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>																	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED					
Charles S. Springate, M.D.						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>						February 20, 1969					
EXAMINER'S NAME (Type)						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						ADDRESS (Street, city, town, or county)					
Charles S. Springate, M.D.																	
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)							
Burial				2/24/69		Lake View Mem. Park				Sykesville, RD. Md.							
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR						25b. REGISTRAR'S SIGNATURE					
J. E. Myers, Jr., Westminster, Md.						FEB 24 1969						[Signature]					

09882

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

100-100000

DEATH CERTIFICATE

Name of Deceased		Sex		Age	
Date of Birth		Place of Birth		Usual Residence	
Date of Death		Place of Death		Cause of Death	
Time of Death		Manner of Death		Medical History	
Physician's Name		Physician's Address		Physician's Signature	
Medical Examiner's Name		Medical Examiner's Address		Medical Examiner's Signature	
Date of Examination		Place of Examination		Signature of Coroner	
Signature of Coroner		Signature of Registrar		Signature of Clerk	
Signature of Nurse		Signature of Doctor		Signature of Assistant	
Signature of Family		Signature of Friends		Signature of Neighbors	
Signature of Community		Signature of Church		Signature of School	
Signature of Government		Signature of State		Signature of Nation	
Signature of World		Signature of Universe		Signature of God	

100-100000

100-100000

100-100000



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or Print) <b>VICTOR</b>			First <b>C.</b> Middle <b>14 YEARS</b> Last			2a. DATE KNOWN OF DEATH MATED <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <b>1969</b>		2b. HOUR <b>4:30 PM</b>		
3. SEX <b>M</b>		4. RACE <b>Colored</b>		5. DATE OF BIRTH <b>Oct. 12, 1900</b>		6. AGE (In years last birthday) <b>68</b> YRS.		7c. DATE PRONOUNCED DEAD <b>Month</b> <b>Day</b> <b>Year</b> <b>1969</b>		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL</b> Md.		
10. CITY OR TOWN OF DEATH <b>Mt. Airy</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Route 2</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Mt. Airy</b>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER <b>Route 2</b>	
14. FATHER'S NAME <b>Charles R. Myers</b>					15. MOTHER'S MAIDEN NAME <b>Martha Smith</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>578-18-6683</b>		17. INFORMANT ADDRESS <b>Mrs. Mary Simms Same As Above</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> <b>517X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary Fibrosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3-4 weeks</b> <b>8 months</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <b>M.C. Porterfield</b>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>M.C. PORTERFIELD</b>					22b. DATE SIGNED <b>2-16-69</b>					
ADDRESS (Street, city, town, or county) <b>HAMPSTEAD, MD</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>2/19/1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodville Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Frederick Co., Md.</b>			
24. FUNERAL DIRECTOR <b>C.M. Waltz, Box 241, Sykesville, Md.</b>					25a. REC'D BY REGISTRAR <b>FEB 19 1969</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

12330

12330

12330

12330

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02262

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

02258

1. DECEASED-NAME (Type or print) Bruce Norman Nicola			2a. DATE OF DEATH Month 2 Day 22 Year 69			2b. HOUR 2:30 A			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH 2-26-1875		6. AGE (In years last birthday) 93 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.			
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) laborer		12b. KIND OF BUSINESS OR INDUSTRY unknown			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Westernport		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 319 Vine Street	
14. FATHER'S NAME First Middle Last unknown			15. MOTHER'S MAIDEN NAME First Middle Last unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 213-24-5942		17. INFORMANT Hospital Records Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, bilateral</u> 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart Disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (a) (this hospital) attended the deceased from 7/28, 1967, to 2/22, 1969, that (b) (we) last saw the deceased alive on 2/22, 1969, and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above, (d) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Frank Y. Patricio				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 2/22/69			
22d. PHYSICIAN'S NAME (Type) Gracito T. Patricio, M.D.				22e. ADDRESS Springfield State Hospital, Sykesv., Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 25, 1969		23c. NAME OF CEMETERY OR CREMATORY Piedmont Cemetery		23d. LOCATION (City or Town) (County) (State) Westernport Allegany Md.			
24. FUNERAL DIRECTOR W. Harold Fredlock		ADDRESS Piedmont, W. Va.		25a. REC'D BY REGISTRAR DATE FEB 26 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

83888

STATE OF NEW YORK

83888

1911

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
XXXXX Rosa Virginia XXXXX O'Haro					2	Month 4 Day 69 Year	8:00 AM	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
female	white		11/28/82		86 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH		
Maryland		USA				Carroll Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Rural--Sykesville		Springfield State Hospital		housewife				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Md.		Carroll		Middleburg		YES <input type="checkbox"/> NO <input type="checkbox"/>		none
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
First Middle Last Charles E. O'Haro		First Middle Last Fannie Esworthy						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
no		218-54-3407		Springfield Hospital records, Sykesville, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) Congestive heart failure								days
4270 DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
(b) DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic brain syndrome associated with senile brain disease with behavioral reaction.								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED White <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (X) (this hospital) attended the deceased from 8/24/1967, to 2/4/1969, that (X) (we) last saw the deceased alive on 2/4/1969, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.								
22b. SIGNATURE						22c. DATE SIGNED		
Naci N. Buyukunsal, M.D.						2/4/69		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		2-7-1969		Mount Olivet Cemetery		Frederick, Frederick, Md.		
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Robert E. Dailey & Son		Frederick, Maryland		FEB 10 1969				

03230

RECEIVED

03230

TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]  
[The remainder of the page contains several paragraphs of extremely faint, illegible text, likely a memorandum or official letter. The text is mirrored across the page, suggesting a bleed-through effect from the reverse side.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <b>Stanley</b> <sup>First</sup> <b>None</b> <sup>Middle</sup> <b>Penman</b> <sup>Last</sup>						2a. DATE OF DEATH Month <b>Feb.</b> Day <b>18</b> Year <b>69</b> <b>XX</b> <b>XX</b> <b>XX</b>			11. HOUR <b>11:20 PM</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>7-16-90</b>		6. AGE (In years last birthday) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS <b>XX</b> DAYS <b>XX</b> HOURS <b>XX</b> MIN.		IF UNDER 24 HRS. HOURS <b>XX</b> MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Allegany U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b> Md.					
10. CITY OR TOWN OF DEATH <b>Sykesville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hosp</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>R.R. Brakeman</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>				13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Barton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First <b>John</b> Middle <b>None</b> Last <b>Penman</b>				15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>Mackey</b> Last <b>Mackey</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Hospital Records</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>4123</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Chronic Phlegm</b>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>12-1-19-32</b> , to <b>2-18-19-69</b> , that (I) (we) last saw the deceased alive on <b>2-18-19-69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Gracito Patricio</b>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>2/18/69</b>			
22d. PHYSICIAN'S NAME (Type) <b>Gracito Patricio</b>						22e. ADDRESS <b>Springfield State Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>2/21/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lanzer Hill Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Westport Alle. Md.</b>					
24. FUNERAL DIRECTOR <b>C. Boal</b>						ADDRESS <b>Westport, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 24 1969</b>		25b. REGISTRAR'S SIGNATURE <b>James J. Smith</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A151  
30M REV. 1-58

MARYLAND STATE DEPARTMENT OF HEALTH																										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																										
CERTIFICATE OF DEATH																										
1. DECEASED-NAME (Type or print)			First EDNA			Middle SEDORA			Last PLUMMER			2a. DATE OF DEATH Month FEBRUARY			Day 6			Year 1969			2b. HOUR 8:45 P					
3. SEX Female			4. RACE Negro			5. DATE OF BIRTH 3-4-04			6. AGE (In years last birthday) 64 YRS.			IF UNDER 1 YEAR MONTHS			IF UNDER 24 HRS. DAYS			HOURS			MIN.					
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Carroll												Md.					
10. CITY OR TOWN OF DEATH Sykesville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY																	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Poolesville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER Jonesville Road														
14. FATHER'S NAME			First William			Middle A.			Last Hall			15. MOTHER'S MAIDEN NAME			First Lyles			Middle Black			Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 577-46-7858			17. INFORMANT Records, Springfield State Hospital			Address														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Severe coronary artery arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Thrombosis of left coronary artery</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Years Minutes														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>CBS associated with cerebral arteriosclerosis, with psychotic reaction. Severe diabetes mellitus.</u>																										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																				
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State																				
22a. I certify that (I) (this hospital) attended the deceased from <u>8-23-66</u> , 19____, to <u>2-6-69</u> , 19____, that (I) (we) last saw the deceased alive on <u>2-6-69</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																										
22b. SIGNATURE <u>Dr. Antonius Glahn</u>			22c. DATE SIGNED 2-7-69			22d. PHYSICIAN'S NAME (Type) Antonius Glahn, M. D.			22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21784																	
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 2-11-69			23c. NAME OF CEMETERY OR CREMATORY ELIJAH Church Cem.			23d. LOCATION (City or Town) (County) (State) Poolesville Montg. Md.																	
24. FUNERAL DIRECTOR <u>George R. Snowden</u>			ADDRESS Rockville Md			25a. REC'D BY REGISTRAR DATE FEB 13 1969			25b. REGISTRAR'S SIGNATURE <u>William S. Judge</u>																	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and to any event, within 72 hours after death.

VR A15  
45M - 1

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or print)			First WILBUR			Middle ALLEN			Last ROCKSTROH			2a. DATE OF DEATH Month FEBRUARY 18, Day 1969 Year 7:20 P M			
3. SEX Male			4. RACE White			5. DATE OF BIRTH 8-9-1890			6. AGE (In years lost birthday) 78 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Carroll Md.						
10. CITY OR TOWN OF DEATH Sykesville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Elevator Operator			12b. KIND OF BUSINESS OR INDUSTRY						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. CITY Baltimore City			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 1214 S. Charles St.			
14. FATHER'S NAME First Unk.			Middle Rockstroh			Last Unk.			15. MOTHER'S MAIDEN NAME First Unk.			Middle Blades			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Unk.			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 217-14-1659			17. INFORMANT Address Records, Springfield State Hospital									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>011.3</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary tuberculosis, active</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic cardiovascular disease</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Years Years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CBS assoc. with cerebral arteriosclerosis, with psychotic reaction</u>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <u>7-19-65</u> , 19____, to <u>2-18-69</u> , 19____, that (I) (we) last saw the deceased alive on <u>2-18-69</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>Jose Chapulle</u>			22c. DATE SIGNED 2-19-69			22d. PHYSICIAN'S NAME (Type) Jose Chapulle, M. D.			22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21784			22f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 2/22/69			23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore Maryland						
24. FUNERAL DIRECTOR ADDRESS KRAUSE FUNERAL HOME 1216 S. Charles St.			25a. REC'D BY REGISTRAR FEB 20 1969			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>									

03350

03350

11/10/50



11/10/50



11/10/50



11/10/50



11/10/50



11/10/50

11/10/50



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02267

02263

1. DECEASED-NAME (Type or Print) <b>John</b> First <b>E.</b> Middle <b>Schmidt</b> Last			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month <b>Feb</b> Day <b>22</b> Year <b>1969</b> 2b. HOUR <b>4:45 p.m.</b>		
3. SEX <b>MALE</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>FEB 23, 1902</b>	6. AGE (In years last birthday) <b>66</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>WESTMINSTER, Md.</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WASHINGTON ROAD</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>FARMER</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>Westminster</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME <b>John Michael Schmidt</b> First <b>John</b> Middle <b>Michael</b> Last <b>Schmidt</b>			15. MOTHER'S MAIDEN NAME <b>MARY Bentreys</b> First <b>MARY</b> Middle <b>-</b> Last <b>Bentreys</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215 16 6735</b>		17. INFORMANT <b>Mrs. Viola Schmidt</b> ADDRESS <b>Westminster, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO, OR AS A CONSEQUENCE OF <b>437.9</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Cerebral Arteriosclerosis</b> (b) <b>hyp.</b> (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20 min</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year <b>19</b> HOUR A.M. <b>0</b> P.M. <b>0</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE <b>Maurice C. Porterfield</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>2-22-69</b>	
EXAMINER'S NAME (Type) <b>M.C. PORTERFIELD</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, City, Town, or County) <b>HAMPSTON, CARROLL, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2-25-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Oakland</b>	
24. FUNERAL DIRECTOR <b>Harry W. Haight</b> ADDRESS <b>Sykesville, Md.</b>		23d. LOCATION (City or Town) <b>Sykesville</b> (County) <b>Md.</b> (State)		25a. REC'D BY REGISTRAR <b>FEB 27 1969</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

02880

OPTIONAL FORM NO. 10 MAY 1962 EDITION GSA FPMR (41 CFR) 101-11.6

UNITED STATES GOVERNMENT

02880

FORM NO. 10  
MAY 1962 EDITION

02880

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-64

02268										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										02264														
CERTIFICATE OF DEATH																																		
1. DECEASED-NAME (Type or print)					First Middle Last					2a. DATE OF DEATH					2b. HOUR																			
ANN MARIA J. STEEL										Feb Month 6 Day 1969					5:40 PM																			
3. SEX					4. RACE					5. DATE OF BIRTH					6. AGE (In years and birthday)					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN.									
Female					Caucasian					Sept. 16, 1872					90 YRS.																			
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH																			
Maryland					U.S.A.										Carroll,																			
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY																			
Middleburg					Brookville Manor Nur. Home					Homemaker					None																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. CITY OR TOWN					13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13d. STREET AND NUMBER																			
Maryland					Frederick					Frederick					901 North Market Street																			
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last																													
Adam Arthur DeVilbiss					Alverdia Lookingbill																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown					16b. SOCIAL SECURITY NO.					17. INFORMANT					Address																			
No					?					Mrs. Helen B. Young					Frederick, Maryland																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 1. DEATH WAS CAUSED BY:																																		
IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u>															10 days																			
4379 DUE TO, OR AS A CONSEQUENCE OF																																		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																																		
(b) <u>Cerebral atherosclerosis.</u>																																		
DUE TO, OR AS A CONSEQUENCE OF																																		
(c)																																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																		
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																								
22a. I certify that (I) (this hospital) attended the deceased from 1967, 19, to Feb 6, 1969, that (I) (we) lost saw the deceased alive on Feb 6, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																		
22b. SIGNATURE <u>Dr. Caricofe</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>															22c. DATE SIGNED 2/6/69																			
22d. PHYSICIAN'S NAME (Type) Dr. Caricofe M.D.															22e. ADDRESS Carroll County, Maryland																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)																			
Burial					2-10-1969					Mount Olivet Cemetery					Frederick, Frederick, Md.																			
24. FUNERAL DIRECTOR <u>Robert E. Bailey &amp; Son</u> ADDRESS Frederick, Maryland															25a. REC'D BY REGISTRAR FEB 11 1969										25b. REGISTRAR'S SIGNATURE									

MEDICAL CERTIFICATION

1988

1988

1988

1988

1988

1988

1988

1988

1988

1988

1988

1988

1988

1988

1988

1988

1988

1988

1988

1988

1988

1988

1988

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
45M - 11-29

<div style="display: flex; justify-content: space-between;"> <span>02269</span> <span>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>02265</span> </div> <div style="text-align: center;"> <b>CERTIFICATE OF DEATH</b> </div>											
1. DECEASED-NAME (Type or print) <b>Richard William Thomas</b>			First Middle Last			2a. DATE OF DEATH February 19, 1969			2b. HOUR 10:50 AM		
3. SEX <b>Male</b>			4. RACE <b>Negro</b>			5. DATE OF BIRTH <b>11-10-05</b>			6. AGE (In years lost birthday) <b>63</b> RS.		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Carroll County Md.</b>		
10. CITY OR TOWN OF DEATH <b>Sykesville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Farmer</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>			13c. CITY OR TOWN <b>Sandy Spring</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME <b>unk.</b>			First Middle Last			15. MOTHER'S MAIDEN NAME <b>Liza Ella Thomas</b>			First Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>None</b>			16b. SOCIAL SECURITY NO. <b>227-09-8447</b>			17. INFORMANT <b>Records, Springfield State Hospital</b>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemiplegia, right-sided, due to</b> <b>4339</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral thrombosis, due to</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized arteriosclerosis</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>CBS, associated with cerebral arteriosclerosis with behavioral reaction</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>6-29-1966</b> , to <b>2-19-1969</b> , that (I) (we) last saw the deceased alive on <b>2-19-1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Octavio A. Ruiz MD</b>						DEGREE <b>MD</b>			22c. DATE SIGNED <b>2-19-69</b>		
22d. PHYSICIAN'S NAME (Type) <b>Octavio A. Ruiz</b>						22e. ADDRESS <b>Springfield State Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>2-23-69</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Sandy Spring Cem</b>			23d. LOCATION (City or Town) (County) (State) <b>Sandy Spring Montg, Md.</b>		
24. FUNERAL DIRECTOR <b>20492 R. Snowden</b>						25a. REC'D BY REGISTRAR <b>Feb 26 1969</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

02225

COMMITTEE OF DEATH

02225



Handwritten text at the bottom of the page, possibly a signature or date.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02270

02266

1. DECEASED-NAME (Type or print) <b>William Stanley Thompson</b>		20. DATE OF DEATH Month <b>2</b> Day <b>7</b> Year <b>69</b>		2b. HOUR <b>6:55</b> P. M.
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>Oct. 5, 1918</b>	6. AGE (In years last birthday) <b>50</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Carroll</b> Md.	
10. CITY OR TOWN OF DEATH <b>Westminster</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Carroll Co. Hospt.</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Guard</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Random House</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>	13b. COUNTY <b>Carroll</b>	13c. CITY OR TOWN <b>Hampstead</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>253 S. Main St.</b>
14. FATHER'S NAME First Middle Lost <b>William S. Thompson</b>		15. MOTHER'S MAIDEN NAME First Middle Lost <b>Pearl E. (Unknown)</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>Yes</b> (If yes give year and dates of service) <b>WW 2</b>		16b. SOCIAL SECURITY NO. <b>212-22-2865</b>		17. INFORMANT Address <b>Mrs. Valerie Thompson Hampstead, Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY INSUFFICIENCY</b> <b>5192</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 WEEKS</b> <b>YEARS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>1964</b> , to <b>2/7, 1969</b> , that (I) (we) last saw the deceased alive on <b>2/7 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>Vincent J. Francis Jr. MD</b>		22c. DATE SIGNED <b>2/7/69</b>		22d. PHYSICIAN'S NAME (Type) <b>Vincent J. Francis Jr. MD</b>
22e. ADDRESS		22f. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Feb. 10, 1969</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Grace Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Upperco, Md.</b>	
24. FUNERAL DIRECTOR <b>Tipton - Eline Funeral Home Hampstead, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 13 1969</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3330

3330

Handwritten notes in the right margin, including the word "Cable" and other illegible text.

Main body of the document containing multiple lines of text, including dates like "1944", "1945", and "1946", and various names and locations. The text is mostly illegible due to fading and bleed-through.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
02271									
02267									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last Dorothy Caroline Tornow					2a. DATE OF DEATH Month 2 Day 1 Year 69			2b. HOUR 11a M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH March 5, 1926		6. AGE (In years last birthday) 42 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.			
10. CITY OR TOWN OF DEATH Sykesville, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Typist		12b. KIND OF BUSINESS OR INDUSTRY Gov't.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 5813 Falkirk Rd.	
14. FATHER'S NAME First Middle Last Ernest Tornow			15. MOTHER'S MAIDEN NAME First Middle Last Mary C Koehl						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 220-30-4608		17. INFORMANT Address Springfield State Hospital, Sykesville, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 486X DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Schizophrenia Reaction, chronic undiff type									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Aug. 4, 1963, to Feb. 1, 1969, that (I) (we) last saw the deceased alive on Feb. 1, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (and I) (we) view the body after death.									
22b. SIGNATURE Dr. Antonius Glahn		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED Feb. 1, 1969			
22d. PHYSICIAN'S NAME (Type) Dr. Antonius Glahn		22e. ADDRESS Springfield State Hosp. Sykesville, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-3-69		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION (City or Town) (County) (State) Balto. Md.			
24. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md.				25. REC'D BY REGISTRAR DATE FEB 4 1969		25b. REGISTRAR'S SIGNATURE Charles J. J...			

1020

204

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 11-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
02272		CERTIFICATE OF DEATH						02268		
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR M	
Mabel Lucy Tuke						Feb 3 1969			10 00	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		Oct 2 - 1884			84 YRS.			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH	
Illinois			U.S.A.						CARROLL Co Md.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Holbrook			CHAPEL HILL NURSING HOME			AT HOME				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
VIRGINIA						Richmond			4822 W. Seminary Ave.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
William F. Tuke			Julia Haydon							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address	
No			-			Isabel T. Thomas - 15 D Cross Keys Rd # 21310				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) COMPLETE OBSTRUCTION COLON.										
1538 DUE TO, OR AS A CONSEQUENCE OF										
(b) METASTATIC CARCINOMA COCON										
DUE TO, OR AS A CONSEQUENCE OF										
(c) CARCINOMA PELVIC ORGANS										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
ASCVD.										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from JAN, 19 68 to 2-3, 19 69, that (I) (we) lost saw the deceased alive on 2-3-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE J. P. Howard, MD						DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2-4-69
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Cremation			2-5-69		Loudon Park Crematory			Baltimore, Md.		
24. FUNERAL DIRECTOR William O. Williams						ADDRESS 4601 LEE HIGHWAY Belt 21207		25a. REC'D BY REGISTRAR FEB 7 1969		25b. REGISTRAR'S SIGNATURE Charles Judge

308501

RECEIVED

1951

10-10-51

10-10-51



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>SIDNEY BENJAMIN TURNER</b>			2a. DATE OF DEATH Month <b>2</b> Day <b>24</b> Year <b>69</b>			2b. HOUR <b>7:00</b> AM			
3. SEX <b>Male</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH <b>11/08/1894</b>		6. AGE (In years lost birthday) <b>74</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b> Md.			
10. CITY OR TOWN OF DEATH <b>Sykesville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Porter</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b> COUNTY <b>---</b>			13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1117 Carey Street</b>		
14. FATHER'S NAME First Middle Last <b>JOHN TURNER</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>POLLY DESCHILDS</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>no</b>			16b. SOCIAL SECURITY NO. <b>212-10-2143</b>		17. INFORMANT Address <b>Hospital Records</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular thrombosis</b> <b>4339</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis (generalized)</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>yrs.</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>CBS associated with cerebral arteriosclerosis with psychotic reaction</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <del>(it)</del> (this hospital) attended the deceased from <b>March 16</b> , 19 <b>65</b> , to <b>Feb. 24</b> , 19 <b>69</b> , that <del>(I)</del> (we) last saw the deceased alive on <b>Feb. 24</b> , 19 <b>69</b> , and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>(I)</del> (we) (did) (do not) view the body after death.									
22b. SIGNATURE <b>Suha Ozgun</b>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>2/24/69</b>	
22d. PHYSICIAN'S NAME (Type) <b>Suha Ozgun, M.D.</b>				22e. ADDRESS <b>Springfield State Hospital, Sykesv., Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2/27/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Charles R. Law, 802 Madison Ave.</b>				25a. REC'D BY REGISTRAR DATE <b>FEB 26 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

•

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02274

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02270

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF ESTI- DEATH MATED				2b. HOUR			
LILLIE		RUTH		WELLS				Feb. 21 1969				12:40 PM			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		2d. HOUR			
Female	Negro	7-5-24		44 YRS.						Feb. 21 1969		12:40 PM			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH									
South Carolina		U.S.A.		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Carroll									
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY			
Sykesville				Springfield State Hospital				Housewife							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
Maryland				Baltimore City		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		753 Lake Drive					
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle Last			
Early		Summers		Bertha		Jones									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No				251-22-6055		Records, Springfield State Hospital									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia. 2952 DUE TO, OR AS A CONSEQUENCE OF Occlusion of larynx of base of tongue Conditions, if any, which gave rise to immediate cause (a), (b) probably during a convulsive seizure. stating the underlying cause last. (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
												mins.			
												mins.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Schizophrenic reaction, catatonic type. Convulsive disorder.															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?							
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				Maurice C. Porterfield M.D.				22b. DATE SIGNED 2/22/69							
EXAMINER'S NAME (Type)				M.C. PORTERFIELD, M.D.				ADDRESS (Street, city, town, or county) HAMPSTEAD, MD							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)					
Burial				2/27/69						COLUMBIA S.C.					
24. FUNERAL DIRECTOR				ADDRESS				25. REC'D BY REGISTRAR DATE				25b. REGISTRAR'S SIGNATURE			
Maurice C. Porterfield				638 N. Green St				FEB 26 1969				Charles Judge			

RECEIVED

1950

1950

1950

1950

1950

1950

1950

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or Print)			First		Middle		Last		
CHERYL			LESLEY		ZEIGLER				
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
female	white	Dec. 16, 1968		— YRS.		MONTHS 2 DAYS 7		HOURS MIN.	
7a. DATE KNOWN OF DEATH			Month		Day		Year		2b. HOUR
February 18,			19		69		8:30		M
7b. BIRTHPLACE (State or foreign country)			7c. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Maryland			U.S.A.					Carroll Md.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Manchester			14 N. Main St.						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Carroll		Manchester				14 N. Main Street
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME
John			W.		Zeigler		Evelyn		Rossmann
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT		ADDRESS	
			--			John W. Zeigler		Manchester, Md. 14 N. Main St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Interstitial Pneumonitis (SDII)</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			Werner U. Spitz, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		2/18/69	
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
						ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
burial			2/20/69		Evergreen Memorial Gardens		Finksburg, Md.		
24. FUNERAL DIRECTOR			ADDRESS			25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
J. J. Myers Jr., Westminster, Md.						FEB 21 1969			

NOV 20 1954

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE  
WASHINGTON, D. C.

100-100000

Name		John	
Address		1000 1st St. N.W.	
City		Washington, D.C.	
State		District of Columbia	
Zip		20001	
Occupation		Student	
Education		High School	
Marital Status		Single	
Date of Birth		10-10-1930	
Place of Birth		Washington, D.C.	
Parents		John Doe, Mary Doe	
Religion		Catholic	
Political Party		None	
Social Security Number		100-100000	
Fingerprints		Noted	
Photograph		Noted	
Signature		John Doe	
Date		11-20-54	
Agent		J. Edgar Hoover	
Special Agent		J. Edgar Hoover	
Assistant		J. Edgar Hoover	
Investigator		J. Edgar Hoover	
Supervisor		J. Edgar Hoover	
Director		J. Edgar Hoover	

100-100000